MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

2003 JOINT APPLICATION FOR HOSPITAL GROUPS

FOR GEOGRAPHIC RECLASSIFICATION

EFFECTIVE FEDERAL FISCAL YEAR 2005

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

THIS APPLICATION MUST BE COMPLETED AND RECEIVED BY THE MGCRB BY **5:00 P.M. EDT, SEPTEMBER 2, 2003**. FAILURE TO COMPLY WILL RESULT IN DISMISSAL.

PRINT IN INK OR TYPE WHEN COMPLETING THIS APPLICATION

I. GROUP INFORMATION

1. NAME OF THE COUNTY OR, IF APPLICABLE, THE NECMA IN WHICH THE HOSPITALS ARE LOCATED: _____

2. IDENTIFICATION NUMBER FOR THE AREA INDICATED IN NUMBER 1 (OBTAIN NUMBER FROM THE INSTRUCTIONS AT TAB 1): _____

3. CONTACT FOR ALL COMMUNICATIONS REGARDING THIS APPLICATION:

NAME: _____
ORGANIZATION: _____
ADDRESS: _____
_____
_____ ZIP CODE - _____
TELEPHONE NUMBER: _____

4. A. THE GROUP SHOULD PROVIDE, USING THE FOLLOWING FORMAT, A LISTING OF ALL PPS HOSPITALS IN THE COUNTY OR NECMA AT **ATTACHMENT A**. COLUMNS A THROUGH C ARE SELF-EXPLANATORY. FOR COLUMN D., PROVIDE AN ASTERISK IF THE HOSPITAL IS ALSO FILING AN INDIVIDUAL APPLICATION WITH THE MGCRB. IN COLUMN E, THE GROUP MUST IDENTIFY ALL HOSPITALS WHICH ARE ALREADY RECLASSIFIED FOR THE WAGE INDEX IN FFY 2005 AS PART OF A 3-YEAR RECLASSIFICATION. COMPLETE COLUMN E BY INDICATING THE AREA IDENTIFICATION NUMBER TO WHICH THE HOSPITAL IS RECLASSIFIED IN FFY 2005. **NOTE:** THE BOARD WILL RULE ON A GROUP RECLASSIFICATION REQUEST BEFORE IT RULES ON A HOSPITAL'S INDIVIDUAL REQUEST. IF THE BOARD RECLASSIFIES A GROUP, IT WILL DISMISS ANY INDIVIDUAL RECLASSIFICATION APPLICATION FILED BY HOSPITALS IN THE GROUP.

COL. A HOSPITAL NAME	COL. B ADDRESS	COL. C MEDICARE PROV. NUMBER	COL. D INDIVIDUAL APPLICATION	COL. E FFY 2004 RECLASS. AREA

B. IN SUPPORT OF 4.A. IMMEDIATELY ABOVE, INCLUDE AS **ATTACHMENT B** A CURRENT LETTER FROM THE APPROPRIATE CMS REGIONAL OFFICE WHICH LISTS ALL OF THE CURRENTLY LICENSED PPS HOSPITALS IN THE COUNTY NAMED IN I.1. ABOVE.

II. RECLASSIFICATION REQUEST

5. THE AREA (RURAL AREA, MSA, OR NECMA) TO WHICH THE GROUP IS REQUESTING RECLASSIFICATION (THE GROUP MAY BE RECLASSIFIED TO ONLY ONE AREA):

_____

6. IDENTIFICATION NUMBER FOR THE AREA SHOWN IN NO.5 (OBTAIN NUMBER FROM THE INSTRUCTIONS AT TAB 1)

_____

7. THE GROUP SHOULD CIRCLE THE RECLASSIFICATION CRITERIA UNDER WHICH IT IS APPLYING AND COMPLETE THE SECTIONS INDICATED:

A. ALL HOSPITALS IN A RURAL COUNTY SEEKING REDESIGNATION TO AN URBAN AREA (42 C.F.R. 412.232). COMPLETE SECTIONS III, IV, V, THE WAGE INDEX COMPARISON, AND THE AFFIDAVIT (S).

B. ALL HOSPITALS IN AN URBAN COUNTY SEEKING REDESIGNATION TO ANOTHER URBAN AREA (42 C.F.R. 412.234). COMPLETE SECTIONS III, IV, VI, THE WAGE INDEX COMPARISON, THE STANDARDIZED AMOUNT COMPARISONS, AND THE AFFIDAVIT (S).

C. ALTERNATIVE CRITERIA FOR HOSPITALS LOCATED IN AN NECMA (42 C.F.R. 412.236). COMPLETE SECTIONS III, VII, AND THE AFFIDAVIT (S).

III. GENERAL INFORMATION

8. ARE ALL PPS HOSPITALS IN THE COUNTY (OR NECMA) LISTED IN NO. 4 MEMBERS OF THE GROUP?:

YES _____ NO _____

9. HAVE THE HOSPITALS IN THE GROUP ALSO REQUESTED RECLASSIFICATION AS A PART OF A STATEWIDE WAGE INDEX APPLICATION FOR FFY 2005?

YES _____ NO _____

10. IF THE GROUP APPLYING FOR RECLASSIFICATION IS AN URBAN GROUP, HAS ANY HOSPITAL LISTED IN NO. 4 ABOVE APPLIED, OR WILL BE APPLYING, TO THE CMS REGIONAL OFFICE TO BE TREATED AS BEING IN A RURAL AREA? (42 C.F.R. 412.103, REFER TO THE INSTRUCTIONS FOR FURTHER INFORMATION):

YES _____ NO _____

IF "YES", PROVIDE A LIST OF THE HOSPITALS AT **ATTACHMENT C.** INDICATE IN THE LIST WHETHER ANY OF THE HOSPITAL APPLICATIONS HAVE BEEN APPROVED AND PROVIDE THE DATE OF THE APPROVAL.

11. IS THE GROUP REQUESTING AN ORAL HEARING?:

YES _____ NO _____

IF "YES" ATTACH RATIONALE UNDER **ATTACHMENT D**.

12. PRIOR YEAR GROUP CASE NUMBER (S):

99G _____ 00G _____ 01G _____ 04G _____

IV. ADJACENCY (ALL GROUPS)

13. IS THE COUNTY OR NECMA IN WHICH THE HOSPITALS ARE LOCATED ADJACENT (CONTIGUOUS) TO THE AREA TO WHICH THE GROUP SEEKS REDESIGNATION?:

YES _____ NO _____

(ATTACH MAP UNDER **ATTACHMENT E**.)

V. METROPOLITAN CHARACTER (RURAL GROUP ONLY)

14. DOES THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED MEET THE STANDARDS FOR REDESIGNATION TO AN MSA OR NECMA AS AN "OUTLYING COUNTY"?:

YES _____ NO _____

(ATTACH THE SUPPORTING BUREAU OF THE CENSUS DATA UNDER **ATTACHMENT F**.)

VI. CMSA CRITERIA (URBAN GROUP ONLY)

15. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED A PART OF THE CMSA THAT INCLUDES THE URBAN AREA TO WHICH THE GROUP SEEKS REDESIGNATION?:

YES _____ NO _____

(ATTACH OFFICIAL BUREAU OF THE CENSUS CMSA LISTING UNDER **ATTACHMENT G**.)

VII. ALTERNATIVE CRITERIA (NECMA GROUP ONLY)

16. WOULD THE NECMA IN WHICH THE HOSPITALS ARE LOCATED BE COMBINED AS PART OF THE NECMA TO WHICH THEY SEEK REDESIGNATION IF THE CRITERIA FOR COMBINING NECMAS WERE THE SAME AS THE CRITERIA USED FOR COMBINING MSAS?:

YES _____ NO _____

(ATTACH BUREAU OF THE CENSUS DATA AND SUPPORTING MATERIAL UNDER **ATTACHMENT H**.)

WAGE CRITERIA - 85 PERCENT COMPARISON (RURAL AND URBAN GROUPS)

ATTACH THE GROUP'S AGGREGATE HOURLY WAGE COMPUTATIONS USING 3-YEAR AVERAGES OF WAGES AND HOURS FOR THE 85 PERCENT COMPARISON UNDER **ATTACHMENT I**.

STANDARDIZED AMOUNT

COMPLETE A COPY OF THE STANDARDIZED AMOUNT COST COMPARISON FOR EACH HOSPITAL IN THE GROUP. ATTACH UNDER **ATTACHMENT J**.

UNDER **ATTACHMENT L**, ATTACH THE COMPUTATION OF THE RATIO OF CASE MIX ADJUSTED COST PER DISCHARGE TO THE THRESHOLD AMOUNT FOR EACH HOSPITAL. ALSO INCLUDE UNDER THIS ATTACHMENT THE DISCHARGE WEIGHTING OF THESE RATIOS AND THE GROUP COST COMPARISON.

UNDER **ATTACHMENT M**, ATTACH A COPY OF EACH HOSPITAL'S MOST RECENTLY FILED COST REPORT, INCLUDING A COPY OF THE ORIGINAL SIGNED CERTIFICATION FOR THAT COST REPORT. (**NOTE:** EACH HOSPITAL'S COST REPORT SHOULD ONLY BE SUBMITTED WITH THE ORIGINAL APPLICATION; NO COST REPORT SHOULD BE ATTACHED TO THE MGCRB'S COPIES OF THE APPLICATION.)

STANDARDIZED AMOUNT RECLASSIFICATION REQUEST

HOSPITAL _____ PROVIDER NUMBER _____

ATTACH THE HOSPITAL'S STANDARDIZED AMOUNT COMPARISON UNDER **ATTACHMENT J.**

a. INDICATE THE MEDICARE COST REPORTING PERIOD FOR THE MOST RECENTLY FILED COST REPORT:

COST REPORTING PERIOD BEGINNING DATE: _____

COST REPORTING PERIOD ENDING DATE: _____

ALL DATA ENTERED IN b. THROUGH j. MUST BE FOR THE COST REPORTING PERIOD INCLUDED IN a. (INCLUDE THE COST REPORT AT **ATTACHMENT M**).

b. TOTAL MEDICARE COSTS (EXCLUDING PASSTHROUGHS):
(FROM WORKSHEET D-1, PART II, LINE 53)

_____

c. TOTAL MEDICARE DISCHARGES:
(FROM WORKSHEET S-3, PART I, LINE 12, COL. 13)

_____

d. DRG AMOUNT - OTHER THAN OUTLIER PAYMENTS:
(FOR COST REPORTING PERIODS ENDING AFTER 11/30/98 FROM WORKSHEET E, PART A, LINE 1 PLUS LINE 1.01 PLUS LINE 1.02)

_____

e. DRG AMOUNT - OUTLIER PAYMENTS:
(FOR COST REPORTING PERIODS ENDING AFTER 11/30/98 FROM WORKSHEET E, PART A, LINE 2 PLUS LINE 2.01)

_____

f. IF THE HOSPITAL USES AN INTERMEDIARY-COMPUTED CASE MIX INDEX (CMI) INSTEAD OF A CMI FROM THE FEDERAL REGISTER, SHOW THE FISCAL INTERMEDIARY'S CMI. DO NOT COMPLETE IF USING A CMI FROM THE FEDERAL REGISTER:

_____

IF A CMI IS ENTERED IN f., ATTACH A COPY OF THE FISCAL INTERMEDIARY LETTER UNDER **ATTACHMENT K**.

g. INDICATE THE HOSPITAL'S INDIRECT MEDICAL EDUCATION ADJUSTMENT FACTOR (S) EXPRESSED IN DECIMALS, NOT RATIOS, AS CALCULATED FOR THE COMPLETION OF LINE 3.21, 3.22 AND 3.23 OF WORKSHEET E, PART A OF THE COST REPORT:

_____

(FOR DISCHARGES OCCURRING PRIOR TO 10/1)

_____

(FOR DISCHARGES OCCURRING ON OR AFTER 10/1 BUT BEFORE 1/1)

_____

(FOR DISCHARGES OCCURRING AFTER 1/1)

h. ENTER THE MEDICAID AND SSI PERCENTAGES EXPRESSED IN DECIMALS, NOT RATIOS. (READ INSTRUCTIONS BEFORE COMPLETING.)

a. MEDICAID _____0._____

(FROM SCHEDULE E, PART A, LINE 4.01)

b. SSI _____0._____

(FROM SCHEDULE E, PART A, LINE 4)

i. a. TOTAL PATIENT DAYS: _____

(FROM WORKSHEET S-3, PART I, LINE 12,COL. 6, LESS LINES 3 AND 4, COL. 6, PLUS LINE 28, COL. 6)

b. TOTAL TITLE XIX (MEDICAID) INPATIENT DAYS: _____

(FROM WORKSHEET S-3, PART I, LINE 12, COL. 5, PLUS LINE 2, COL. 5, LESS LINES 3 AND 4, COL. 5)

j. INDICATE THE HOSPITAL'S BED SIZE: _____

(FROM WORKSHEET S-3, PART I, LINE 12, COL. 2 LESS LINE 11, COL. 2 LESS LINES 3 & 4, COL. 6 LESS LINE 26, COL. 6)
DIVIDED BY (NUMBER OF DAYS IN THE COST REPORT PERIOD)

AFFIDAVIT

COUNTY OR PARISH OF_____

STATE OF_____

I, _____ (TYPE OR PRINT NAME), BEING DULY SWORN, DEPOSE AND SAY AS FOLLOWS:

(1) I CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING APPLICATION FOR GEOGRAPHIC RECLASSIFICATION AND ALL OF THE SUPPORTING INFORMATION AND DATA INCLUDED IN THE SUBMITTAL BY _____ _____ (HOSPITAL NAME AND MEDICARE PROVIDER NUMBER) THAT IS DUE TO THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD NO LATER THAN SEPTEMBER 2, 2003. I HEREBY DECLARE UNDER PENALTY OF PERJURY (28 U.S.C. SECTION 1746) THAT THE FOREGOING IS TRUE AND CORRECT.

(2) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE GROUNDS FOR DENIAL OF THE HOSPITAL'S APPLICATION.

(3) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE CAUSE FOR LEGAL ACTION AGAINST THE APPLICANT HOSPITAL AND ITS OFFICIALS.

(4) I CERTIFY THAT I AM AN OFFICER OF THE HOSPITAL NAMED IN (1) ABOVE OR A CORPORATE OFFICER OF THE HOSPITAL'S PARENT CORPORATION WITH AUTHORITY TO SIGN THE APPLICATION FOR GEOGRAPHIC RECLASSIFICATION ON BEHALF OF THE HOSPITAL.

SIGNATURE: _____

TITLE: _____

PHONE NUMBER: _____

SUBSCRIBED AND SWORN BEFORE ME
THIS _____ DAY OF _____2003
(DAY) (MONTH)

_____
(SIGNATURE OF NOTARY)

NOTARY PUBLIC
MY COMMISSION EXPIRES: _____